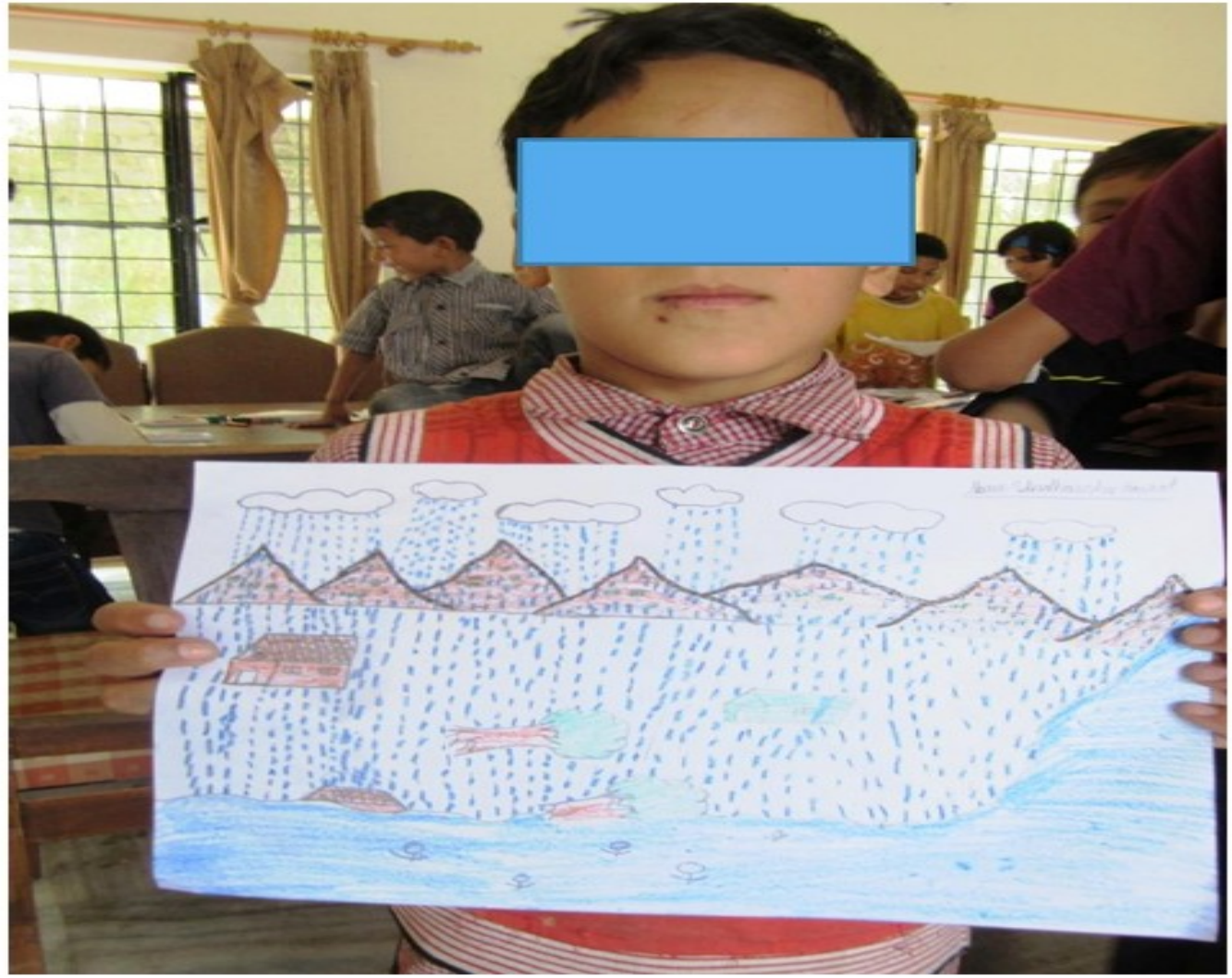
# Types of Mental Health Crisis

- **Maturational (Developmental) Crises**
  Occur during normal life transitions.
- **Situational Crises**
  Sudden, unexpected events that disrupt daily life.
- **Adventitious Crises**
  Caused by external, often violent or uncontrollable events.
- **Sociocultural Crises**
  Arise from broad societal or cultural changes affecting communities.

# What is **catastrophic crisis** ?

- A **catastrophic crisis** is typically an **Adventitious Crisis**.
- **external, sudden, and often violent events** beyond an individual’s control.
- Examples include **natural disasters** (earthquakes, floods, hurricanes), **wars**, **terrorist attacks**, or **riots**.



A eight year old child had drawn his encounter with rain and floods. This drawing be utilized by the trained mental health professionals to do debriefing and cognitive restructuring

# Need

- Emergencies cause widespread psychological distress. 1 in 5 affected people develop serious mental disorders. Mental health services are often disrupted. Those with pre-existing conditions face higher risks. Immediate psychiatric care is essential to reduce suffering and prevent long-term harm
- The effects of emergencies are not just short-term; they can have **long-term psychological and social consequences**
- Mental health and psychosocial well-being are essential to human rights, peace, development.

# Key Facts: Psychiatric *emergency*

- Almost all people affected by emergencies experience psychological distress, which typically improves over time.
- One in five people (22%) who have experienced war or conflict in the previous 10 years has depression, anxiety, post-traumatic stress disorder, bipolar disorder or schizophrenia.
- Emergencies significantly disrupt mental health services and reduce the availability of quality care.
- People with severe mental health conditions are especially vulnerable during emergencies and need access to mental health care and other basic needs.

# Problems & Challenges

| Type | Examples |
| --- | --- |
| **Social problems** | Poverty, social exclusion, family separation, loss of livelihood, reduced trust, disrupted social networks |
| Mental health problems | Pre-existing: depression, schizophrenia; Emergency-induced: grief, acute stress, anxiety, PTSD; Harmful substance use |
| Service challenges | Damaged facilities; staff shortages; high demand; insufficient training ; Primary care gaps; Supply chains; Coordination gaps; Insufficient resources |

# Prevalence & Affected Groups

- Psychological distress (anxiety, sadness, fatigue, irritability etc.) is common and often improves with time
- ~22% have diagnosable disorders in conflict settings Mild conditions (~13%) vs moderate/severe (~9%) in conflict settings
- Higher prevalence in older persons, women, persons with prior mental health conditions

# Principle of disaster mental health

- Based on principles of “preventive medicine“, shifting from individual-focused treatment to **community-level interventions**.
- Emphasis on **health promotion, prevention, planning, and capacity building** of affected communities.
- Marks a **paradigm shift**: from curative, relief-centered response → to **holistic, integrated community approaches**.
- Guided by the **Six “Rs”**:

1. **Readiness** – Preparedness before disaster.
2. **Response** – Immediate action during crisis.
3. **Relief** – Sustained rescue and support.
4. **Rehabilitation** – Long-term recovery using community resources.
5. **Recovery** – Returning to normalcy.
6. **Resilience** – Building strength to withstand future crises.

# Phases of Disaster Mental Health

**1. Heroic Phase** – Survivors engage in altruistic actions (rescue, shelter, support). Lasts days to weeks.
**2. Honeymoon Phase** – Arrival of relief, media, officials, and aid creates hope and optimism. Lasts 2–8 weeks.
**3. Disillusionment Phase** – Relief and support fade, media and officials withdraw, survivors face bureaucratic hurdles and corruption. Optimism declines, mental health morbidity is high. Role of mental health professionals becomes critical.
**4. Restoration Phase** – Survivors gradually adapt, focus shifts to rebuilding and rehabilitation, and community recovery begins over the long term

# Common characteristics of catastrophes:

1. Large number of victims
2. Destruction/damage of resources (including emergency and response services)
3. Gap between needs and available resources/abilities
4. Psychological reactions that may hinder rescue/protection activities
5. Urgent interventions often carried out automatically
6. Positive human responses: aid and solidarity from unaffected areas

# Common mental health problems among adults were

- Relapse of any pre-existing psychiatric disorders
- Adjustment disorders / Abnormal grief
- Anxiety disorders like panic disorders, phobic disorders NOS, Non -specific anxiety symptoms and startle response
- Acute stress reactions
- Insomnia
- Depression / death wishes / suicidal ideas or attempts
- Substance abuse & dependence (Monetary relief given is spent on substance abuse)
- Post -traumatic stress disorders
- Non-specific somatic symptoms such as dizziness, head ache, body ache, recollection of the disaster events through images & thoughts, night mares, night terrors and so forth
- Dissociative symptoms
- Somatoform disorders

Common mental health problems among children were

- Non-specific symptoms such as dizziness, vertigo, startle response, sleep wake cycle disturbances, clinging behavior, excessive crying, withdrawal, fear, anger, irritability, numbing of affect, food refusal and decreased appetite and regressive behavior.
- School refusal, school dropout and academic decline
- Anxiety disorders like panic disorders, phobic disorders NOS, non specific anxiety symptoms and so-forth
- ODD symptoms
- Conduct symptoms – like truancy, stealing, lying and so forth
- Post- traumatic stress disorders
- Depression
- Somatoform disorders

# Role of mental health professionals and disaster functionaries

I. During pre-disaster period (preparedness)

1. Public Education Activities – Life skills education, educating about the disaster mental health
2. Disaster Response Network – to develop collaboration with various existing agencies like governmental agencies, NGO‟s and community health workers
3. Disaster response training of trainers in – a. disaster mental health b. first aid training (both medical and psychological) c. counseling skills d. stress management e. identifying common mental disorders and referral f. life skills training
4. Psycho education regarding mental health in trauma/disaster for the general population
5. Community level support and community resilience training
6. Strengthening Information, Education and Communication (IEC) activities

# II. Immediately after the disaster (heroic and honeymoon phases)

1. Being part of the multi-disciplinary relief team
2. Rapid assessment (mental health surveillance) a. magnitude of the psychological impact b. available mental health resources in the affected community c. needs assessments d. social, cultural and religious perspective of the community
3. Providing health care a. medical and psychological first aid b. the pre-existing mentally ill patients c. substance intoxication and withdrawal in survivors d. crisis intervention e. establishing the referral system
4. Providing targeted disaster mental health interventions to the needy
5. Disaster psychiatry outreach teams to provide care
6. Promotion of resilience and coping
7. Dealing with the victims and volunteers stress (stress management)
8. Fostering the mass grieving / mourning
9. Collaborating with administrative and funding agencies
10. Mental health education – do‟s and do not‟s a. Educating the administrative personnel, local leaders and public b. Utilizing mass media to reach the survivors
11. Initiating collaboration with the local agencies for capacity building and outside agencies for support
12. Planning research

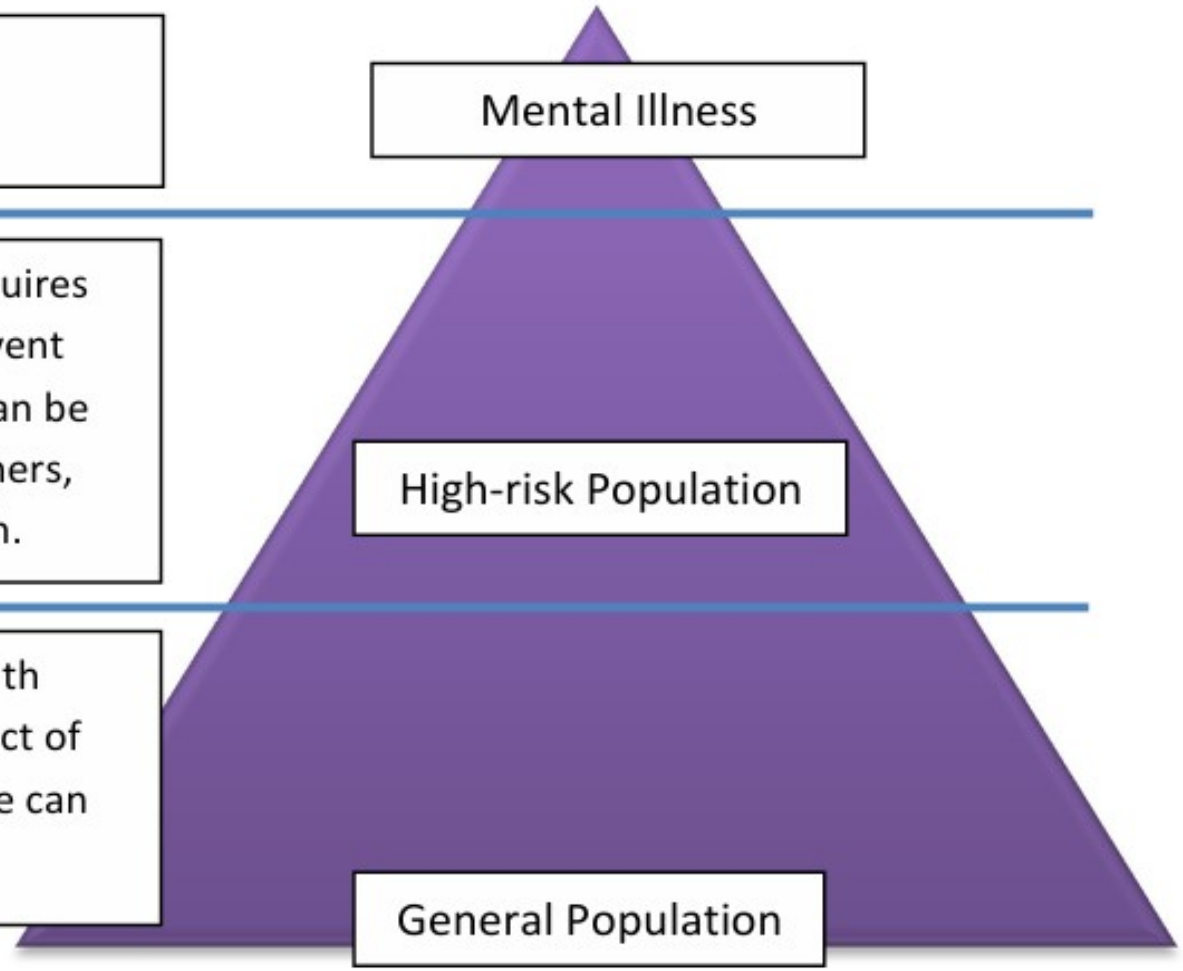
# III. During disillusionment phase

1. Providing care for the mental ill patients
2. Attending to the referrals
3. Continuing and expanding the capacity building activities
Training of resourceful community members like private physicians/doctors, primary health care staff, paramedical staffs, school teachers, anganwadi workers, alternative complementary medicine personnel‟s, religious leaders, spiritual leaders and faith healers
4. Community outreach camps
5. Hand holding of the community health workers
6. Assessment of the interventions and feedback mechanism

Early treatment and rehabilitation of the survivors by mental health professional.

Disaster exposed high-risk population requires simple mental health intervention to prevent the development of mental illness. This can be delivered by the trained volunteers, teachers, survivors, community leaders and so forth.

Disaster exposed population. Mental health promotion is required to reduce the impact of disaster. Promotion of Mental Health Care can be done by public at large.



# Three-Tier Approach for Mental Healthcare in Disasters

- **Public Education / Awareness**
  - Life skills education and **disaster mental health awareness** for the general population and volunteers.
  - **Psychoeducation** about trauma, stress reactions, and coping strategies.
- **Disaster Response Network**
  - Collaboration with **government agencies, NGOs, and community health workers**.
  - Focus on **training of trainers** in disaster mental health.
- **Training Components for Responders**
  - **Disaster mental health principles**
  - **Medical and psychological first aid**
  - **Counseling skills**
  - **Stress management**
  - **Identifying common mental disorders and referral pathways**
  - **Life skills training**
  - **Yoga, meditation, and spirituality** for holistic support

# Recommended Actions / Strategies

- Strengthening first-line contact: making sure affected populations can access basic psychological first aid (PFA) and other psychosocial services locally.
- Include Mental Health & Psychosocial Support (MHPSS) in all emergency preparedness plans
- Establish cross-sectoral technical working group for coordination
- Strengthen community self-help and social support, engage vulnerable groups
- Train frontline workers in Psychological First Aid Provide information & messaging to foster positive coping and encourage help-seeking
- Ensure clinical care available for priority conditions via general health facilities, using evidence-based protocols (e.g. mhGAP-HIG) Offer evidence-based psychological interventions for those with prolonged distress

# Recommended Actions / Strategies

- Protect rights of people with severe mental health conditions, including those in institutions
- Establish referral networks among specialists, general health, community, social services etc.
- Integrating mental health into broader health services rather than treating it as a separate/specialized afterthought.
- Decentralizing specialized resources so that services are not only in big urban centers but reach those in more remote or heavily affected areas
- The “Mental Health and Psychosocial Support Minimum Service Package (MHPSS-MSP)” is highlighted as a tool to help humanitarian actors coordinate, plan, implement, and allocate resources

# “Building Back Better” – Opportunities

- Emergencies provide chance to strengthen systems during recovery phase

Examples:

- *Syrian Arab Republic*: expansion beyond hospital-based care into primary/secondary/social settings even during conflict.
- *Sri Lanka* after 2004 tsunami: reform, decentralization, infrastructure improved.
- *Philippines* after Typhoon Haiyan: large training of community workers, scaling up of services.

# Implications

- Policy level: integrate MHPSS into disaster risk reduction, national health policy
- Operational: training, supply chain strengthening, coordination
- Community: destigmatization, awareness, inclusion of marginalized/vulnerable groups
- Monitoring & evaluation: assess mental health outcomes, ensure quality

# Common Psychiatric Emergencies

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- Psychotic Symptoms
- Severe Anxiety / Panic Attacks
- Substance-Related Emergencies
- Aggression or Violence
- Acute Trauma / Stress Reactions
- Domestic Violence and Women’s Mental Health Crises
- Adolescent Addiction
- Workplace Stress / Occupational Mental Health Crises
- Victims of Disaster / Catastrophic Events
- Catatonia / Severe Motor Disturbances
- Severe Eating Disorders
- Suicide as a National Emergency

# REFERENCES


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